VIRTUAL
2020 NATIONAL
RYAN WHITE
CONFERENCE ON
HIV CARE & TREATMENT

Like a Phoenix Rising: Lessons Learned From Building a Clinical Quality Management (CQM) Program

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Disclosures

- Presenter has no relevant financial or non-financial interests to disclose.
- Commercial support was not received for this activity.

Presentation Objectives

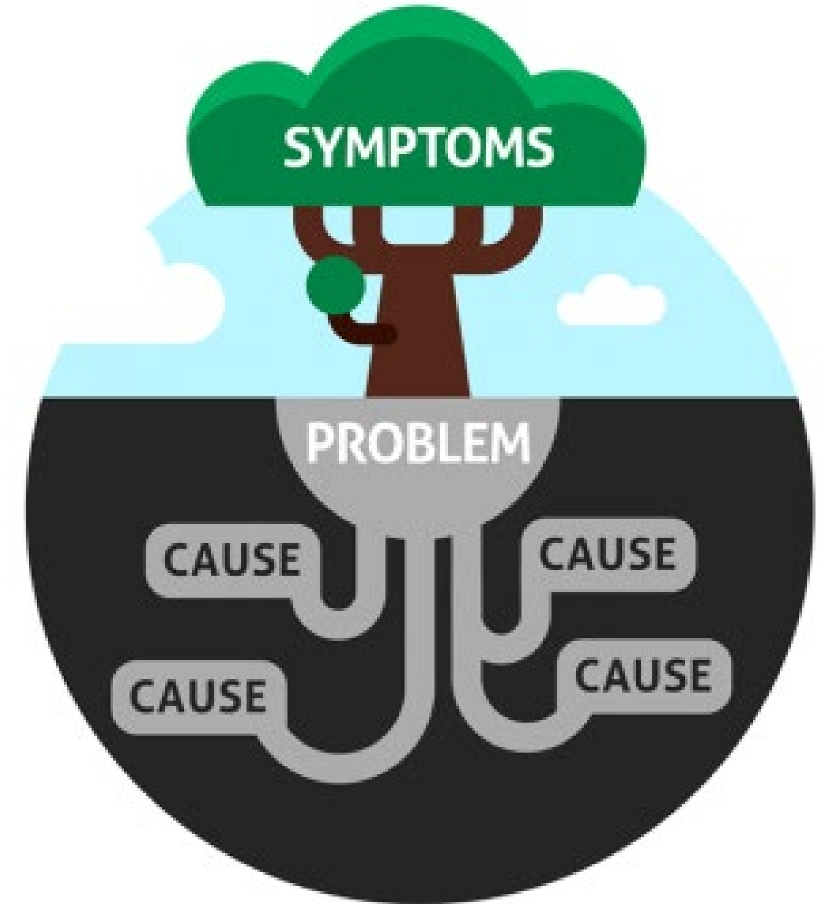
- Describe a successful and newly implemented quality management program at the Massachusetts Department of Public Health (MDPH) Office of HIV/AIDS (OHA)
- Identify best practices for building scalable and easily replicable CQM programs
- Identify opportunities for collaboration in the development of a responsive CQM program

Why are we here?

- Share the Part B perspective as we built (and continue to build) a Clinical Quality Management (CQM) program that aligns with PCN 15-02
- Share some best practices we learned along the way and highlight where we missed the mark
- Share our perspective on how to successfully build a culture of quality internally (at the health department) and externally (with stakeholders and subrecipients)
- Talk about our next steps and hopes and dreams for CQM

Getting to the root of the problem

- April 2016 HRSA site visit identified a few key findings
- The bottom line: we didn’t have a formal CQM program that aligned with 15-02
- Lots of activities designed to improve the system already existed, but we lacked an infrastructure
- No client level data system to support CQM work
- Staff were not assigned to CQM as part of their roles



The QI/QM Journey

30 YEARS
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Phase 1	Phase 2	Phase 3	Phase 4	Phase 5	Phase 6
No Knowledge of QI	**Not Involved with QI Activities**	**Informal or Ad Hoc QI Activities**	**Formal QI Activities Implemented in Specific Areas**	**Formal Agency-Wide QI**	**QI Culture**
Leadership and staff do not understand QI	Leaders understand and staff are beginning to understand QI	Staff may view QI as an added responsibility	Multiple QI champions are well known among staff as QI experts and mentors	Several QI champions exist throughout the agency	QI knowledge and skills are strong across majority of staff
Agency performance is not monitored; decisions are not data-driven	Simple, informal elements of QI exist (evaluation activities, some data collection)	Discrete QI projects may occur but not fully aligned with steps in a QI model	Use of formal QI is well used in certain areas of the agency	Progress and outcomes related to QI and strategic goals are reported widely and routinely	Every staff member is held accountable with QI competencies in evaluations

THINK BIG
START small

Humble beginnings

- Within the first two years post-HRSA site visit, we tackled the “small” stuff first:
  - We wrote a formal CQM plan and sought TA from HRSA to review it
  - We identified staff and re-imagined how CQM would fit into existing infrastructure
  - We selected CAREWare and onboarded our subrecipients
  - We sent two staff to attend the Center for Quality Improvement and Innovation (CQII) Training of Trainers program
  - We formed an internal CQM Committee
  - We trained all staff internally at MDPH on the basics of quality improvement
  - We joined- and led the reimagining of- the Statewide Quality Management Network
  - We met routinely with our Part A counterparts to prioritize coordination and reduce duplication of efforts

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Next stop: Subrecipient CQM

- Once we felt confident in our ability to support our subrecipients in CQM, we released our plans and expectations to the field
- MDPH funds an integrated set of HIV/HCV/STI/TB prevention, linkage, and retention in care and treatment services
  - 44 agencies total funded to provide services (22 receive Part B funding)
  - Part B funded services include: Medical Case Management, Medical Transportation, Oral Health Services, Medical Nutritional Therapy, Other Professional Services, Housing Services, Outreach Services
  - Adherence support funded through ADAP Flexibility Program
  - State’s AIDS Drug Assistance Program administered by a community-based organization (and has been for 25 years)
  - Number of Part B subrecipients also receive Ryan White Parts A, C, and D funding

Subrecipient CQM

- Subrecipient CQM system built on the QI principle of finding success through small, incremental changes
- Recognize the tension between wanting to proceed slowly, with intention vs. jumping in and forging ahead
- Subrecipients are managing enough already, so we wanted this to feel manageable

Subrecipient CQM

- Convened a meeting of all Part B subrecipients in November 2018
  - Attendees included program managers, data staff, and existing staff responsible for quality improvement
  - Oriented providers to CQM expectations, including those in PCN 15-02
  - Explained the difference between QA/QI/CQM, highlighting that most of their current work was QA and the goal was to transition to QA informing QI work
  - Attendees participated in a QI activity (coin spinning game)
  - Provided overview of PDSA cycle and asked attendees to work in groups to design a PDSA based on a provided example
  - Outlined next steps for the providers in terms of implementation and monitoring of CQM activities

Subrecipient CQM: Lessons Learned

- Short and concise "bursts" of information were favored over lengthy onboarding process
- Leverage what you already have- in our case that was seasoned Part C program directors that became quality champions

Jumping in: System QI Activities

- System efforts largely focused on improving performance of the Massachusetts HIV Drug Assistance Program
- Initial QI activities aimed to improve HDAP application turnaround time
- Subrecipient that administers ADAP embraced CQM, including formalization of internal CQM committee to guide internal agency QI work
- Just completed first wide-scale test of change (using PDSA) which included implementation of self-attestation
- Reduced application turnaround time from high of eight weeks to just under two weeks for all applications

Jumping in: Subrecipient QI Activities

- Post-QI convening, focus on finalizing guidance and tools for Part B funded subrecipients
- MDPH CQM Committee accepted our recommendation that early efforts were more prescriptive:
  - All Part B subrecipients would use PDSA in the first year of QI activities
  - All Part B subrecipients would be assigned one of three projects:
    - Improving rate of timely service plan development among medical case management clients
    - Improve rates of STI screening among sexually active PLWH
    - Improve timely enrollment and retention into the Massachusetts HIV Drug Assistance Program

Jumping in: Subrecipient QI Activities Begin!

- Subrecipients were assigned projects in May 2019 to align with the start of next state fiscal year (beginning July 1, 2019)
- We provided benchmark data to all subrecipients to frame their QI projects
- We conducted calls with all Part B subrecipients during the first three months of the QI project- checking in on the "Do" phase of the PDSA
- We conducted additional trainings (more on that later) to support implementation of QI activities
- We continue to evaluate (with our CQM Committee) the impact of our work

Culture of Quality

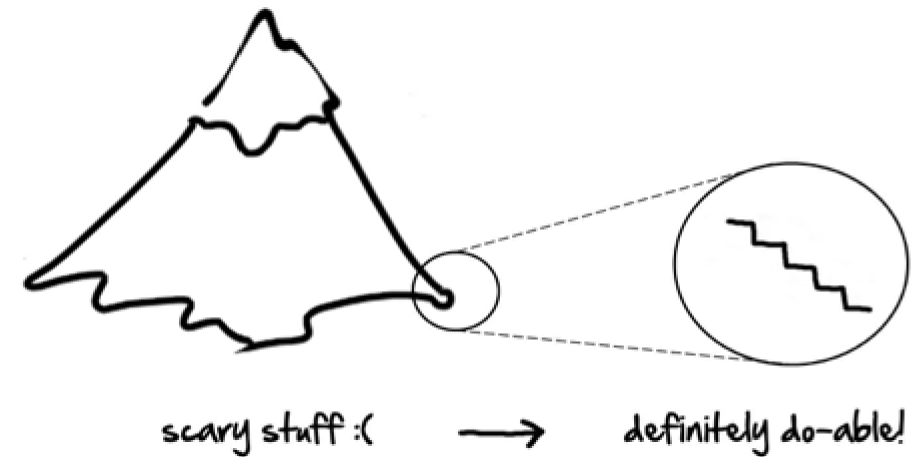
- Once QI activities were underway, we launched a second phase of our QI training program focused on building a culture of quality among all agency staff
- Recognized that buy-in needs to begin on the front lines, so the training was geared towards direct care staff (e.g. case managers, benefits staff, community health workers, peers)
- Oriented around basic principles of quality improvement
- Asked providers to think about how they can use QI in their day-to-day work even if they aren't assigned a "QI" role

What is a culture of quality?

- Shared commitment to making things better for our clients, patients, colleagues and ourselves
- A belief that should always ask:
  - WHY we do things a certain way?
  - WHAT we get out of doing it that way?
  - HOW could we do it better?
  - WHO should be involved in making it better?
- Participation is ESSENTIAL, not OPTIONAL– we're all in this together
- Failure is OKAY, it is EXPECTED, and incredibly HELPFUL
- Bottom line: it's always about the people we serve

Best Practices

- Don’t reinvent the wheel-- many people are out there doing great work. Use it!
- Be reasonable with early expectations- tackle only what you can reasonably accomplish
- Favor being overly prescriptive early to ensure universal understanding
- Be as collaborative as possible
- Don’t be afraid of course corrections!



Lessons Learned

- Be patient. We thought this would take 12-18 months. It took almost four years
- Collaboration isn’t as easy as it seems
- Ask for help. Especially from HRSA. They were critical partners in our journey
- Practice what we preach. It’s not going to always work, but so much can be learned from these moments

CQM Hopes and Dreams

- In the next round of QI activities, shift from a prescriptive approach to allowing subrecipients to determine their own QI journey
- Better utilize the data we have available to us, including CAREWare, surveillance, ADAP, and medical case management acuity data
- Shift from process driven projects to clinical outcomes driven projects
- Use the CQM infrastructure to support goals of Integrated HIV/AIDS Prevention and Care Plan, including improving health outcomes of PLWH and reducing pervasive health disparities
- Expanded staffing capacity to support CQM program

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QUESTIONS?